

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-028150

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 278Primary Registration District No. 3054Registrar's No. 97

FILED JUL 25 1962

1. PLACE OF DEATH

a. COUNTY

PIKE

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR
TOWN

LOUISIANA

Length of stay in 1b

15 HRS

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR
INSTITUTION

PIKE Co. HOSPITAL

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

PIKE

admission)

c. CITY
OR
TOWN

FRANKFORD

Inside Limits

Yes ☒ No ☐d. STREET
ADDRESS

(If outside, give location)

Reside on Farm

Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First

LENA

Middle

D'ARLENE

Last

CLICK

4. DATE
OF
DEATH

Month

JULY

Day

17

Year

1962

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

4-30-1908

9. AGE (last birthday)

62

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

CENTER Mo

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

JAMES H. BOND

13b. MOTHER'S MAIDEN NAME

EDITH CRIGLER

14. NAME OF HUSBAND OR WIFE

CLYDE CLICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

CLYDE CLICK

Address

FRANKFORD Mo.

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

Coronary Thrombosis
left Ventricular Stenosis
HypertensionINTERVAL BETWEEN
ONSET AND DEATHPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?YES ☐ NO ☐

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from July 1, 1962 to July 17, 1962 and last saw her alive on July 17, 1962Death occurred at 11:05 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

E. P. Hansen D.O.

22b. ADDRESS

Frankford

22c. DATE SIGNED

7-19-62

23a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

23b. DATE

JULY 19-1962

23c. NAME OF CEMETERY OR CREMATORY

FAIRVIEW CEMETERY

23d. LOCATION (City, town, or county)

FRANKFORD

Mo.

24. FUNERAL DIRECTOR

ADDRESS

MEGOWN FUNERAL HOME FRANKFORD Mo

25. DATE RECD. BY LOCAL REG.

July 19-1962

26. REGISTRAR'S SIGNATURE

Dorise Collier

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

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VS 300
Rev. 4/59

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13 2-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Geo. M. Collier

Licensed Embalmer No. 3839
P. O. Address Louisiana, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.